MISSOURI DIVISION OF HEALTH – STANDARD CERTIFICATE OF DEATH

ARTMENT OF PUBLIC HEALTH AND WELFARE

62-004127
STATE FILE NUMBER

AMENDED

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 1315

FILED FEB 7 1962

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. | SHOULD READ | INSTEAD OF | DATE AMENDED

BY AFFIDAVIT OF | DOCUMENT

1. PLACE OF DEATH
a. COUNTY
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN: ST. LOUIS
Length of stay in 1b
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION: ALEXIAN HOSP.
Inside Limits Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Mo
b. COUNTY
c. CITY OR TOWN: ST. LOUIS
Inside Limits Yes ☐ No ☐
d. STREET ADDRESS (If outside, give location): 3447 HALLIDAY
Reside on Farm Yes ☐ No ☐

3. NAME OF DECEASED (Type or print): First PETER Middle P. Last LOIDA

4. DATE OF DEATH: Month JAN Day 29 Year 1962

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. Married ☐ Never Married ☐ Widowed ☑ Divorced ☐

8. DATE OF BIRTH: JUNE 27, 1889

9. AGE (last birthday): 72

IF UNDER 1 YEAR: Months Days
IF UNDER 24 HR: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED PAINTER

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country): BOHEMIA

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13a. FATHER'S NAME: JOHN LOIDA

13b. MOTHER'S MAIDEN NAME: ANNA DVORAK

14. NAME OF ~~HUSBAND~~ OR WIFE: ANNA LOIDA (Dec'd)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: ROBERT LOIDA Address: 6328 HANCOCK

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute myocardial infarction	3 days
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b)	Arteriosclerotic heart disease	several weeks
DUE TO (c)	420.0	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days. ☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from 1-15-62 to 1-29-62 and last saw him alive on 1-29-62

Death occurred at 4:30 A m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): John D. Loida

22b. ADDRESS: 3739 Grasso

22c. DATE SIGNED: 1-30 62

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE: FEB 1, 1962

23c. NAME OF CEMETERY OR CREMATORY: S.S. PETER & PAUL

23d. LOCATION (City, town, or county) (State): ST. LOUIS Mo.

24. FUNERAL DIRECTOR: Thomas Kutis ADDRESS: 2906 Grasso

25. DATE RECD. BY LOCAL REG.: JAN 30 1962

26. REGISTRAR'S SIGNATURE: Earl Smith, M.D.

D22-6377

11-30-1930 P.M.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Eleanor Province

Licensed Embalmer No. 3403

P. O. Address 2906 Groveland

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.